benefits coverage that has an aggregate actuarial value, as determined under § 440.340, that is at least actuarially equivalent to the coverage under one of the benchmark benefit packages described in § 440.330 for the identified Medicaid population to which it will be offered.

(b) *Required coverage.* Benchmark-equivalent health benefits coverage must include coverage for the following categories of services:

(1) Inpatient and outpatient hospital services.

(2) Physicians' surgical and medical services.

(3) Laboratory and x-ray services.

(4) Well-baby and well-child care, including age-appropriate immunizations.

(5) Emergency services.

(6) Family planning services and supplies and other appropriate preventive services, as designated by the Secretary.

(c) *Additional coverage.* (1) In addition to the categories of services of this section, benchmark-equivalent coverage may include coverage for any additional services in a category included in the benchmark plan or described in section 1905(a) of the Act.

(2) If the benchmark coverage package used by the State for purposes of comparison in establishing the aggregate actuarial value of the benchmark-equivalent package includes any of the following four categories of services: Prescription drugs; mental health services; vision services; and hearing services; then the actuarial value of the coverage for each of these categories of service in the benchmark-equivalent coverage package must be at least 75 percent of the actuarial value of the coverage for that category of service in the benchmark plan used for comparison by the State.

(3) If the benchmark coverage package does not cover one of the four categories of services in paragraph (c)(2) of this section, then the benchmark-equivalent coverage package may, but is not required to, include coverage for that category of service.

§ 440.340 Actuarial report for benchmark-equivalent coverage.

(a) A State plan amendment that would provide for benchmark-equivalent health benefits coverage described in § 440.335, must include an actuarial report. The actuarial report must contain an actuarial opinion that the benchmark-equivalent health benefits coverage meets the actuarial requirements set forth in § 440.335. The report must also specify the benchmark coverage used for comparison.

(b) The actuarial report must state that it was prepared according to the following requirements:

(1) By an individual who is a member of the American Academy of Actuaries (AAA).

(2) Using generally accepted actuarial principles and methodologies of the AAA.

(3) Using a standardized set of utilization and price factors.

(4) Using a standardized population that is representative of the population involved.

(5) Applying the same principles and factors in comparing the value of different coverage (or categories of services).

(6) Without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used.

(7) Taking into account the ability of the State to reduce benefits by considering the increase in actuarial value of health benefits coverage offered under the State plan that results from the limitations on cost sharing (with the exception of premiums) under that coverage.

(c) The actuary preparing the opinion must select and specify the standardized set of factors and the standardized population to be used in paragraphs (b)(3) and (b)(4) of this section.

(d) The State must provide sufficient detail to explain the basis of the methodologies used to estimate the actuarial value or, if requested by CMS, to replicate the State's result.

§ 440.345 EPSDT services requirement.

(a) The State must assure access to early and periodic screening, diagnostic and treatment (EPSDT) services through benchmark or benchmark-